Missouri Department of
SOCIAL SERVICES
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Executive Order 98-12 Implementation Report for Fiscal Year 2009

MISSOURI DEPARTMENT OF
MENTAL
HEALTH

Executive Summary

- Executive Order 98-12 requires the Department of Social Services (DSS) and the Department of Mental Health (DMH) to report to the Governor on their collaboration on mental health matters, including activities related to managed care.

- DSS and DMH enjoy a positive working relationship and continue to work collaboratively on a number of projects to improve mental health services for Missourians. This positive working relationship is making a difference to the people the departments mutually serve.

- For managed care mental health, outcomes have improved from the inception of the collaboration. Generally, managed care mental health outcomes have also improved during the last year.

- Variations in inpatient admissions have been experienced during the course of our collaboration. Data does not suggest a definitive cause, but the increase in admissions in the last year continues a negative trend. Inpatient days have similarly varied over time and increased in the past year.

- Managed care mental health readmission rates have improved in the most recent year. This successfully reverses the prior negative trend.

Managed Care Indicators	**Movement Since EO 98-12** (Change 1999 to 2008 unless noted)	**Movement from Prior Year** (Change 2007 to 2008)
Mental Health Penetration Rates	●	●
➢ Ages 0-12 Years	●	●
➢ Ages 13-17 Years	●	●
Mental Health Inpatient Admissions Per 1,000	●	●
Mental Health Inpatient Days Per 1,000	●	●
Mental Health Outpatient Visits Per 1,000	●	●
Mental Health Ambulatory 7-Day Follow Up After Discharge	●	●
Mental Health Ambulatory 30-Day Follow Up After Discharge	●	●
Mental Health Inpatient Readmission Rate	● (Note: 2004 to 2008)	●
● Positive ● Unchanged ● Negative		

- Case management is a tool targeted at people in the fee for service population with schizophrenia and chronic diseases. It is pursued for high-risk participants who are likely to experience complications requiring additional services in the short term. Case management has substantially increased the number of participants linked to a medical home and a mental health home. Initial results show a decrease in hospital emergency room usage and improved adherence to treatment plans in general.

- The Behavioral Pharmacy Management (BPM) physician-oriented intervention is also used to manage mental health outcomes in the fee for service population. The table *(below)* shows both BPM participants and the comparison group had improved results when looking at six months prior to six months post control period. BPM participants were 7.3% less likely to be admitted to the hospital, had 0.15 fewer average hospital admissions, had 1,813 fewer hospital days for all cases, and had on average $1,238 less non-pharmacy medical costs when comparing their pre- and post-exposure to the program. While indicators did improve for the comparison group, changes were far less substantial.

Fee for Service Indicators (Based on Behavioral Pharmacy Management Participation)	**Behavioral Pharmacy Management Participants**	**Comparison Group**
Admitted to a Hospital	●	●
Mean Hospital Admissions	●	●
Total Hospital Days for All Cases	●	●
Total Hospital Days for All Cases	●	●
● Positive ● Unchanged ● Negative		

- Other important collaborative efforts between the departments include:

  - Non-Pharmaceutical Mental Health Services Prior Authorization Advisory Committee – Reviews and makes recommendations regarding the prior authorization process to the MO HealthNet Division for non-pharmaceutical mental health services.

  - Clinical Consultation – As requested by MO HealthNet, DMH provides utilization reviews for the medical necessity of hospital admissions, appropriate length of stay and quality of treatment.

  - Mental Health and Juvenile Policy Group – Addresses the needs of youth involved in the juvenile justice system by improving utilization and quality of mental health assessments.

- Substance Abuse Treatment Referral Protocol for Pregnant Women Participating in MO HealthNet –Continue to utilize a protocol to facilitate referral of pregnant women in managed care in need of substance abuse treatment to the Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) program.

- System of Care Public Policy Activities – As mandated by Senate Bill 1003, the Children's Mental Health Reform Act, DMH is charged in partnership with other child care agencies and community stakeholders to draft a plan to establish a Comprehensive Children's Mental Health System. Significant components of the plan include diverting or transferring children from state custody, financing of community-based services, improving the assessment process of youth, establishing screening protocols and developing consistent standards of care.

- Missouri Department of Mental Health and MO HealthNet Prescribing Practices Project – To improve patient outcomes by improving psychiatric prescribing practices, improving continuity of care across multiple prescribers, and improving patient adherence to medication treatments for MO HealthNet patients.

Introduction

Executive Order 98-12 was signed on August 12, 1998. This order requires the Department of Social Services (DSS) and the Department of Mental Health (DMH) to collaborate on mental health matters, including activities related to managed care. An annual report is submitted to the Governor's Office.

In the ensuing years the Department of Social Services, particularly the MO HealthNet Division (MHD), and the Department of Mental Health have established a strong and consistent collaborative working relationship that is focused on quality and accountability.

Executive Order 98-12 orders the Departments of Social Services and Mental Health to:

- Collaborate in developing, implementing, and maintaining a structure of managed care that increases the quality, access, availability, cost efficiency, and consumer satisfaction of managed care behavioral health services;
- Jointly address current concerns about the management of behavioral health care in the managed care program by sharing the expertise and knowledge of each department in their respective fields;
- Determine the managed care populations at risk, identify behavioral health needs of those individuals, and secure the most appropriate behavioral health treatment under the terms of managed care contracts;
- Develop strategies to build behavioral health systems capacity in underserved areas.

In addition, Executive Order 98-12 requires the Departments of Social Services and Mental Health to jointly:

- Analyze covered services;
- Establish reviews of health-related consumer grievances and provider appeals under the terms of managed care contracts;
- Establish behavioral health sentinel indicators;
- Identify required data, participate in data analysis and establish outcomes based on data analysis;

- Design and implement the quality assurance process for behavioral health; and,
- Participate in targeted reviews as necessary.

Executive Order 98-12 also requires the Departments of Social Services and Mental Health to collaborate to:

- Develop and evaluate Requests for Proposals;
- Participate in contract compliance reviews and readiness reviews of behavioral health organizations and managed care organizations; and
- Develop strong, clear, mandatory language regarding client rights in the client handbook.

The following summary lists activities and accomplishments in the designated areas, as well as references to additional collaborative activities. All of the above-designated areas are referenced, with the single exception of the final item. Mandatory client rights language has been addressed previously and has not had additional activity during the past year.

Executive Order 98-12 Collaboration

Managed Care Quality Assessment and Improvement Advisory Group. The MO HealthNet Division has used the Managed Care Quality Assessment and Improvement Advisory Group to work with stakeholders to improve services.

The Quality Assessment and Improvement Advisory Group includes representatives from the Department of Mental Health. A DMH representative chairs the Quality Assessment and Improvement Behavioral Health Task Force. The MO HealthNet Division uses the Behavioral Health Task Force to address important issues of quality.

Establishment of Comparable Quality Indicators for Managed Care Health Plans[1]. Managed care health plans self report a variety of indicators for mental health services. Indicators include overall penetration, penetration by age group, inpatient days per 1,000 members, residential days per 1,000 members, inpatient admissions per 1,000 members, inpatient substance abuse days per 1,000 members, inpatient substance abuse admission per 1,000 members, outpatient visits per 1,000 members,

[1] Indicators are commonly defined and based on HEDIS (Health Employer Data Information Set) definitions.

alternative services per 1,000 members, intensive outpatient visits per 1,000 members, ambulatory follow up within thirty days of inpatient discharge, and ambulatory follow up within seven days of inpatient discharge. Indicators are analyzed to monitor overall system operation and to determine trends. Review of recent data reported by health plans has indicated several trends in MO HealthNet managed care mental health, such as:

- The penetration rate has continued to show a consistent annual increase, with an overall 65.0% increase among the 0-12 year age category and a 94.4% increase among the 13-17 year age category from 1999 to 2008. (This is a positive trend.)

- Managed care inpatient admissions per 1,000 increased by 18.1% between 2001 and 2008. (This is a negative trend.)

- Inpatient days per 1,000 increased by 5.3% from 2007 to 2008 for an overall increase of 26.3% since 1999. (This is a negative trend.) However, it is notable that the average length of stay decreased slightly in 2008, such that the increase in inpatient days can be attributed to the higher number, not increased duration, of inpatient stays.

- Outpatient visits per 1,000 increased by 108% between 1999 and 2008, with a 12.6% increase between 2007 and 2008. (This is a positive trend.)

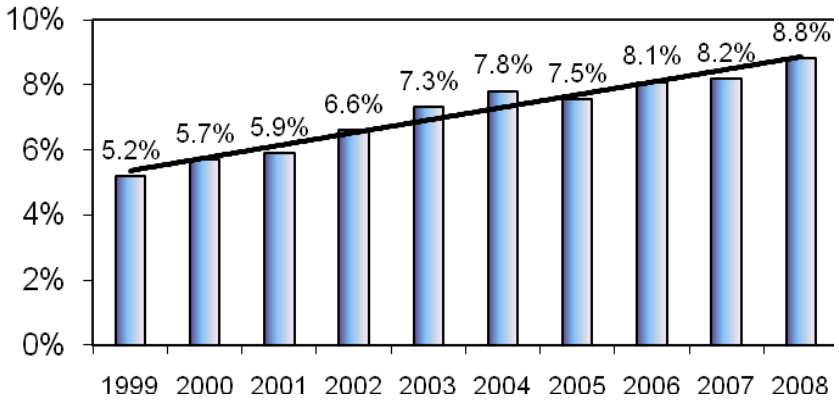
- The ambulatory follow up after discharge 7-day indicator was 47.0% in 2008. This is more than two and a half times the 1999 rate and the increase in 2008 puts Missouri ahead of the national rate (42.5%) for the first time in the course of this collaboration. (This is a positive trend.)

- The ambulatory follow up after discharge 30-day indicator indicates performance was equal to or greater than the national mean during 2001, 2002, 2003, 2005, 2006, 2007, and 2008. The 2008 rate of 70.2% was nearly double the 1999 rate and betters the national average rate (61.0%) by the highest margin we have seen in the course of this collaboration. (This is a positive trend.)

- The inpatient readmission rate decreased in 2008 to 8.1%. This reverses the previous trend of increasing readmissions, but is still 15.7% higher than the 1999 rate. (This is a positive trend for 2008.)

Managed Care Mental Health Penetration[2]. The ten-year penetration rate trend in overall access *(Figure 1)* indicates a fairly consistent annual increase. There has been a 69% improvement in penetration performance between 1999 and 2008, with the greatest overall access rate seen during the last three years (2006 through 2008). Health plans continue to identify methods aimed at increasing member penetration (i.e., use of member educational and clinical case management activity).

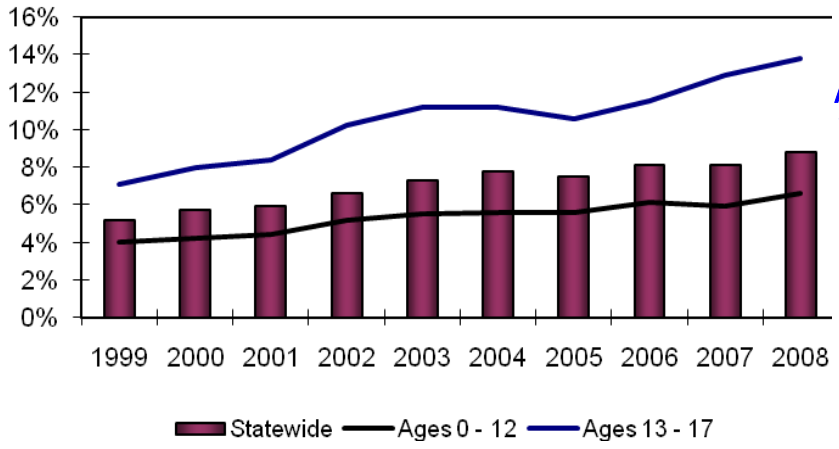
Figure 1. Managed Care Mental Health Penetration Rates
(Ten Year Trend)



Positive Trend

A drill down in member penetration was performed to focus on child health access *(Figure 2)*. Over the past ten years, penetration in mental health services has seen a 65.0% increase among the 0-12 year age category and a 94.4% increase among the 13-17 year age category. Overall, there has been an increasing penetration rate among children with a decrease in the 13-17 year age category occurring in 2005.

Figure 2. Managed Care Mental Health Penetration



Positive Trend

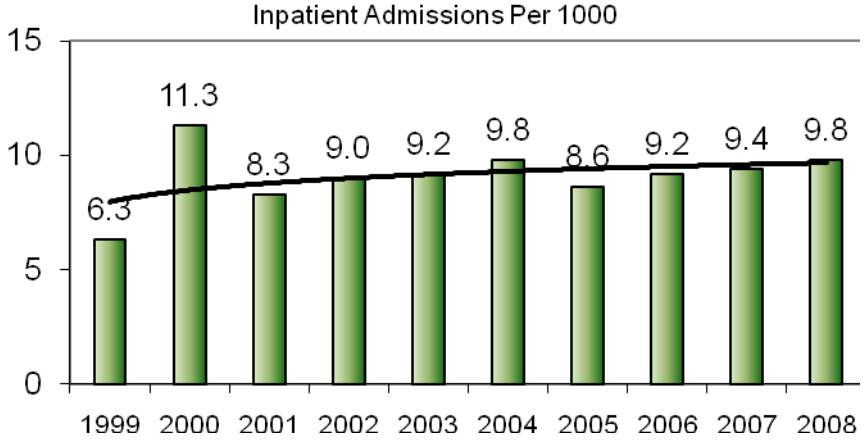
Source for Figures 1 and 2: Missouri Managed Care Health Plan Mental Health Utilization Data

This data will have to be monitored to determine if there are special cause variations that can be identified. The strongest penetration rates can be seen in the 13-17 year age category.

[2] Penetration is a measure of the percentage of plan members accessing mental health services through managed care.

Managed Care Mental Health Admissions. Mental health admissions per 1,000 *(Figure 3)* have increased by 4.2% in 2008 as compared to the prior year. Admissions have increased by 18.1% between 2001 and 2008. Variations in the data during 2000 and 2005 will need to be monitored to determine if there are special cause variations that can be identified.

Figure 3. Managed Care Mental Health Inpatient Admissions Per 1000

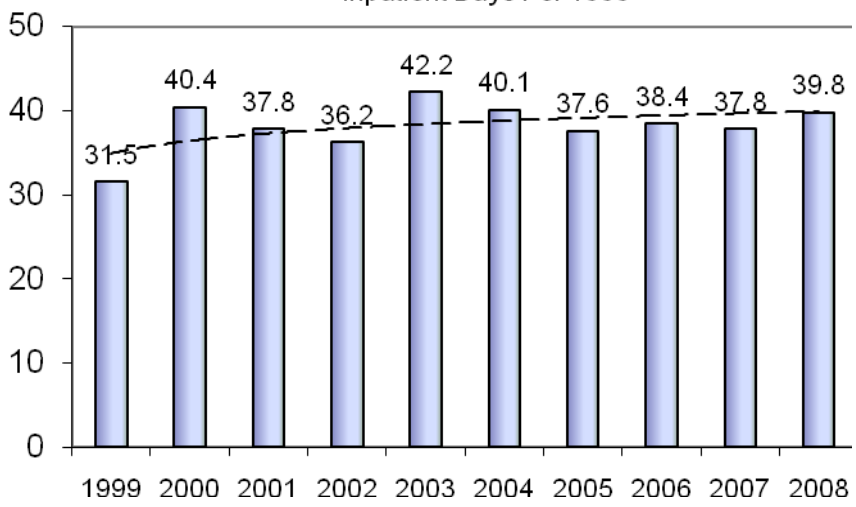


Negative Trend

Managed Care Inpatient and Outpatient Mental Health Services.

Mental health inpatient days per 1,000 *(Figure 4)* increased during 2008 by 5.3% from the prior reporting year. Between 2002 and 2003, there was a six-day increase in the average number of mental health inpatient days. The variation during 2003 may be random and will need to be monitored closely to determine if there are any special cause variations related to member demographics or other variables that may be contributing to higher hospital access and length of stay data. It should be noted that analysis shows that the average length of stay decreased slightly during 2008.This means that the increase in inpatient days is not attributable to longer stays in hospital but rather reflects the increased number of inpatient admissions.

Figure 4. Managed Care Mental Health Inpatient Days Per 1000

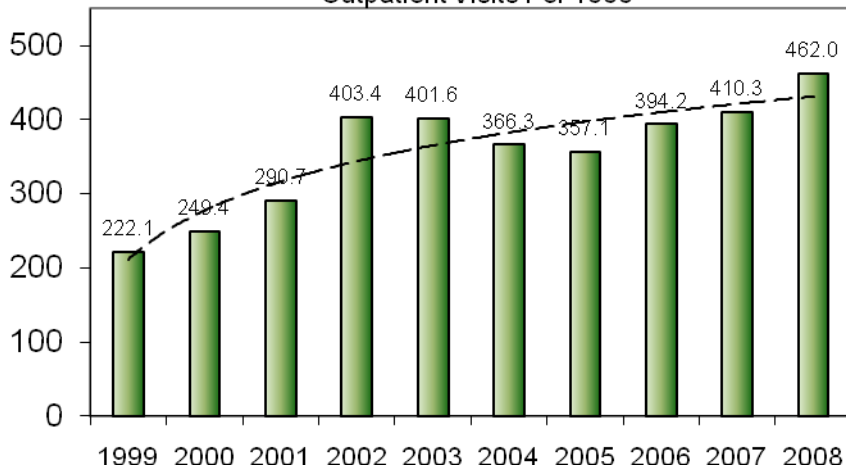


Negative Trend

Source for Figures 3 and 4: Missouri Managed Care Health Plan Mental Health Utilization Data

Mental health outpatient visits per 1,000 *(Figure 5)* have increased by 108% between 1999 and 2008 with a 12.6% increase in visits per 1,000 between 2007 and 2008. There was a 39% increase between 2001 and 2002. An upward trend in outpatient visits is a desirable trend. Multiple factors could be contributing to the increase in utilization including increased advocating for conjoint therapy with both a therapist and a psychiatrist when a member calls in to obtain an authorization solely for a psychiatrist. There has been an increased focus on improving the ambulatory follow-up rates, which can increase authorization for outpatient care. An increase in authorization of in-home therapy sessions has increased rates of members keeping scheduled appointments in turn increasing outpatient utilization.

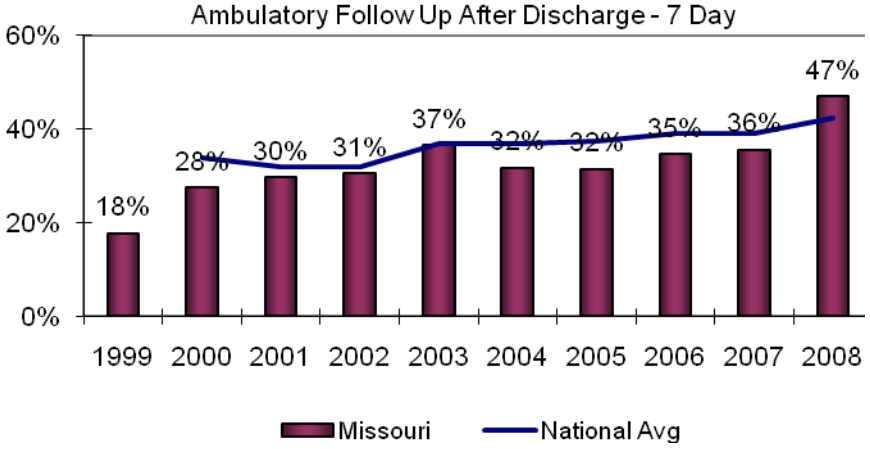
Figure 5. Managed Care Mental Health Outpatient Visits Per 1000



Positive Trend

Managed Care Ambulatory Follow Up. Ambulatory follow up after a mental health discharge *(Figures 6 and 7)* continues to be an important indicator of quality at the national level. Ambulatory follow-up rates are reported by health plans across the country on an annual basis and are reported by the National Committee for Quality Assurance[3] as an effectiveness of care measure. The national mean rates are used as a comparison to the managed care health plan performance (national data is available going back to 2000). In 2008 the 7-day rate for Missouri was 47.0% -- well ahead of the national rate of 42.5%.

Figure 6. Managed Care Mental Health Ambulatory Follow Up After Discharge - 7 Day



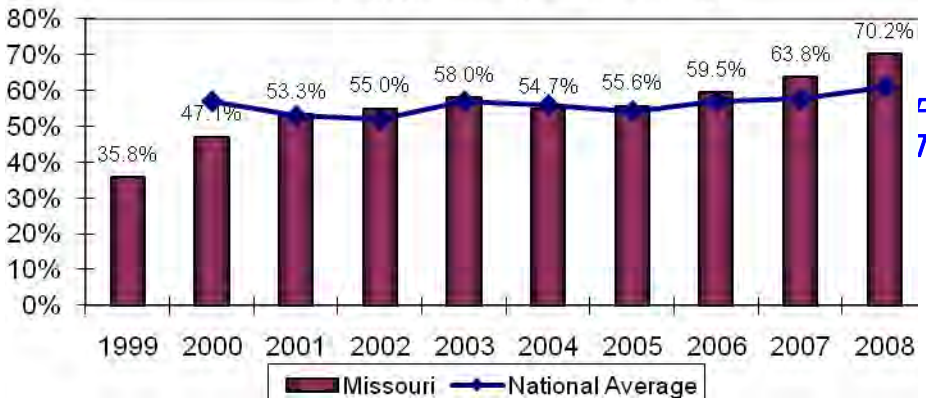
Positive Trend

Source for Figures 5 and 6: Missouri Managed Care Health Plan Mental Health Utilization Data

[3] National Committee for Quality Assurance is an independent, 501(c)(3) non-profit organization whose mission is to improve health care quality everywhere.

Since 2004, Missouri's rate of ambulatory follow up within 30 days *(Figure 7)* has outperformed the national average, and in 2008 did so by the widest margin seen over the course of this collaboration – in 2008 the Missouri rate was 9.2% better than the national average.

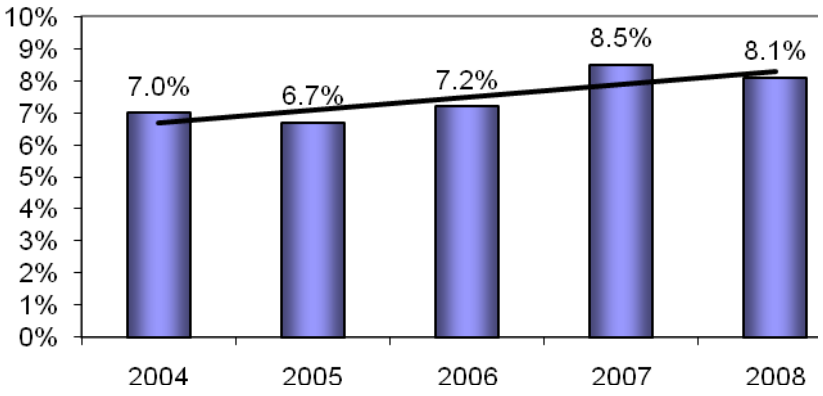
Figure 7. Managed Care Ambulatory 30-Day Follow Up After Discharge



Positive Trend

Managed Care Inpatient Readmission Rate. Mental health inpatient readmissions *(Figure 8)* increased between 2004 and 2007. This overall (negative) trend has reversed in 2008. However, the 2008 rate is still 15.7% higher than the benchmark 2004 rate and so the reversal, while desirable, should be interpreted with some caution as additional progress will be required before this can be considered a new overall trend.

Figure 8. Managed Care Inpatient Readmission Rate



Positive Trend for 2008

Source for Figures 7 and 8: Missouri Managed Care Health Plan Mental Health Utilization Data

The MO HealthNet managed care health plans' efforts to address participant readmission must thereby continue and include, but are not limited to:

- Working with participants, facilities, and outpatient providers to increase member adherence with follow-up appointments and expanding current hospital to home programs;
- Referring participants with co-morbid and high psychiatric acuity to intensive case/disease management programs; and
- Including physical and behavioral health professionals in the management of the MO HealthNet managed care participants.

Additional Interdepartmental Collaboration

Care Management for Persons with Schizophrenia and Chronic Diseases. On a quarterly basis, the DMH analyzes the MHD fee-for-service claims to identify MO HealthNet participants who are at high risk and are likely to experience complications requiring additional services in the coming six months. Health care providers are sent summary reports of the identified participants' medical conditions and health care service history along with recommendations for improving care. Mental health case managers assist participants in accessing necessary medical care. This project has substantially increased the number of participants linked to both a medical home and a mental health home utilized for the goal of meeting their total health care needs. Initial results show a decrease of hospital emergency room usage and improved adherence to treatment care plans in general.

The study found statistically significant differences between the pre- and post-exposure periods for all of the primary outcomes of interest – rates of hospitalizations, mean number of admissions to a hospital, total patient hospital days and total non-pharmacy charges.

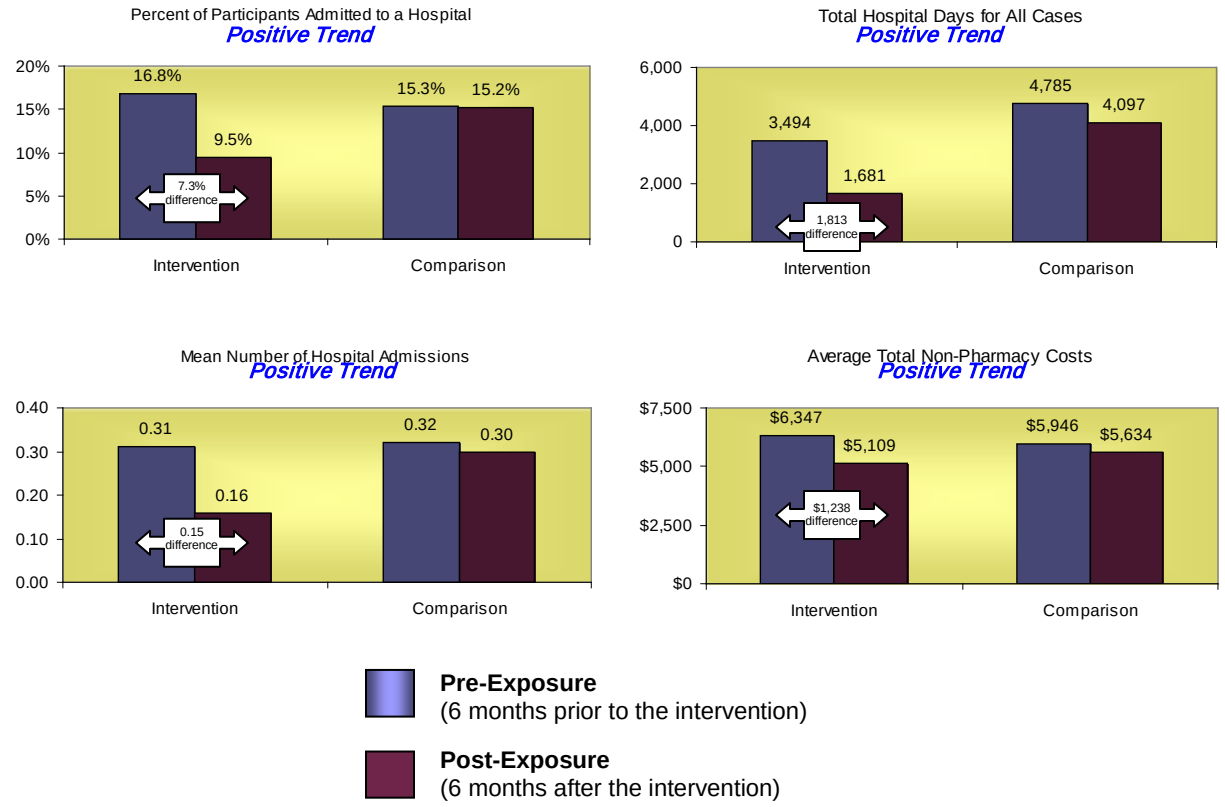
The Behavioral Pharmacy Management (BPM) physician-oriented intervention is associated with a decrease in hospitalizations as evidenced by reductions in the overall rates of admission, the mean number of admissions per patient, and the total patient days. In addition, there is an overall reduction in the total average medical services cost of care for MO HealthNet participants.

There were 7.3% less recipients admitted to the hospital, a decrease of 0.15 mean number of hospital admissions, a decrease of 1,813 total hospital days for all cases, and $1,238 decline in average total non-pharmacy costs *(Figure 9)*.

There were no statistically significant changes in any of the primary outcomes within the comparison group between the two time periods. This indicates that there were no time influences on admissions or payments during the time period of analysis.

The relatively low cost intervention (BPM) helps the state to identify the MO HealthNet participants who are of greatest concern from a financial perspective.

Figure 9. Behavioral Pharmacy Management



Non-Pharmaceutical Mental Health Services Prior Authorization Advisory Committee. The DMH actively participates in the Non-Pharmaceutical Mental Health Services Prior Authorization Advisory Committee, which reviews and makes recommendations regarding the prior authorization process to MHD. Two DMH Clinical Directors and practicing clinicians participate in the committee as mental health experts representing multiple disciplines. The DMH Clinical Directors actively participate in the development of practice guidelines and ongoing clinical consultation regarding the authorization of non-pharmaceutical mental health services.

Clinical Consultation. As requested by MHD, the DMH provides utilization review for the medical necessity of admission and appropriate length of stay, as well as quality of treatment for inpatient hospital stays.

The DMH Clinical Director regularly participates in and provides technical assistance in mental health areas to the following MO HealthNet Division committees:

- Drug Utilization Review Committee;

- Non-Pharmaceutical Mental Health Services Advisory Committee;
- Managed Care Quality Assessment and Improvement Advisory Group;
- APS HealthCare/Chronic Care Improvement Program Quality; and
- Improvement Advisory Committee

In addition, the DMH Clinical Director for Children, Youth and Families provides clinical consultation to the Department of Social Services Children's Division on youth with severe mental health needs that require specialized, individualized care.

Mental Health and Juvenile Justice Policy Group. The Mental Health and Juvenile Justice Policy Group was formed in 2005 in response to a National Policy Academy on improving services for youth involved in the juvenile justice system. A state level team attended the National Policy Academy and established and expanded agency participation to address the needs of this population of youth, including youth who are delinquent and youth under the court's jurisdiction for abuse/neglect. Representatives from Department of Social Services, including Children's Division, Division of Youth Services and MHD, serve on this state group. The team's initial priority was to improve utilization and quality of mental health assessments within the juvenile court and child welfare system. The Office of State Courts Administrator and DMH applied for and received a grant through the Office of Juvenile Justice and Delinquency Prevention to provide a field demonstration on improving the quality of mental health services to youth in the juvenile justice system. Guidelines for conducting evaluations for child welfare and juvenile justice were developed and sites were trained on these guidelines in the five selected grant sites. Sites also selected an evidence based practice to address the needs of the identified population. Two sites were trained on Trauma Focused Cognitive Behavior Therapy, one site on Dialectical Behavior Therapy, one site on Motivational Interviewing and Strengthening Families, and one site selected both prevention and intervention school strategies that targeted substance abuse.

The Mental Health and Juvenile Justice Policy Team is now focusing on youth with problem sexual behaviors. The Team has attempted to examine the prevalence of youth with these issues and how they are identified and treated in the system. There is not a consistent and effective mechanism to address the safety needs of this population. The team has developed a joint vision and guiding principles for working with this population and is now exploring different approaches and interventions.

Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care. During state fiscal year 2009, the DMH Division of Alcohol and Drug Abuse and MHD continued utilization of a protocol to facilitate referrals of pregnant women in

managed care in need of substance abuse treatment to Comprehensive Substance Abuse Treatment and Rehabilitation Program (CSTAR), particularly to the specialized Women and Children CSTARs. The protocol guides collaboration between the primary care providers, CSTAR providers, health plan case managers, and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services.

The protocol facilitates communication between stakeholders by providing geographic locations and contact information for CSTAR treatment programs and health plans. A multi-party consent to release information form is included in the protocol to document the pregnant women's informed consent for appropriate sharing of information between referring and treating entities. CSTAR providers are required to communicate sentinel treatment events to primary care providers and health plan case managers. CSTAR providers are also required to involve primary care providers and health plan case managers in the pregnant women's continuing care plans. The Division of Alcohol and Drug Abuse Clinical Utilization Review Unit will monitor referral to CSTAR treatment programs through the protocol and ensure appropriate communication between the primary care providers and health plan case managers. The Division of Alcohol and Drug Abuse Clinical Utilization Review Unit submits quarterly reports to the MHD that track referrals and follow-up communication activities and issues for review.

System of Care Public Policy Activities. The Children's Division continues to partner with the DMH on a variety of system of care related activities. Senate Bill 1003, the *Children's Mental Health Reform Act*, was passed by the General Assembly and signed by the Governor during 2004. Among its provisions was the charge that the DMH, in partnership with other child serving state agencies and community stakeholders, craft a plan to establish a Comprehensive Children's Mental Health System for Missouri. This plan was submitted to the Governor and General Assembly in December 2004.

A. Comprehensive System Management Team.

The Comprehensive System Management Team (CSMT) was formed in support of Senate Bill 1003 and provides state level interagency implementation leadership on policies, programs and practice. Representatives from all child-serving agencies including, the three Divisions within the Department of Mental Health, the Children's Division, the Division of Youth Services, the Department of Elementary and Secondary Education, MO HealthNet, the Office of State Courts Administrators, local courts, the Department of Public Safety, four federally funded System of Care sites along, with parents and advocacy groups serve on the Comprehensive System Management Team. The goal of the CSMT is to implement the Comprehensive Children's Mental Health Plan. Specific accomplishments through the end of FY08 were outlined in the *2008 Status of Children's Mental Health in Missouri Comprehensive Children's Mental Health System.* In the spring of 2009 the CSMT conducted a strategic planning session to established new goals and objectives.

Institutionalizing System of Care (SOC) values throughout the cultures of all Missouri child-serving organizations continued to be a high priority. In the spring of 2009 a retreat was held for CSMT members to develop a strategic plan followed by ways to move those goals and strategies forward. The CSMT agreed to explore the "Public Health Model" and consider using it as a framework to guide all future work in addressing prevention and early intervention, in addition to serving the most severe children and youth. The SOC website was updated to make the site more interactive with its readers. The website includes information of interest, links and updates relevant to all audiences within the stakeholder community, including families, youth, providers, agencies, schools, etc. Quality Service Reviews (QSR) continues to be conducted at SOC sites with data to be used for planning, policy, and funding recommendations. The QSR process has been manualized at all levels. A 2008 Annual Report on the *Status of Children's Mental Health in Missouri Comprehensive Children's Mental Health System* was forwarded to the Children's Service Commission. An annual update is now in process and will be forwarded to the Commission in December.

B. Stakeholders Advisory Group

The Stakeholders Advisory Group (SAG) worked towards increasing recruitment, particularly of family/youth representatives, and began plans to develop a strategic plan and operating guidelines. Ten out of twelve sites have QSR data to be reviewed by the SAG, who will then provide feedback to CSMT. Plans were made to train more family members or youth to be QSR reviewers. To date 15 family members have been trained statewide. Family leadership training was expanded to include additional communities or groups. The purpose of this training is to prepare youth and families to effectively participate on committees or work groups at a local, regional, and statewide level.

Reducing Number of Youth in State Custody Solely to Access Mental Health Services. This continues to take a two-prong approach. The Custody Diversion Protocol implemented statewide in December of 2004 and the Voluntary Placement Agreement in February of 2005, through a partnership between the DMH and the Children's Division, allow the state to divert children from state custody solely to access mental health services. Extensive training has occurred across the state since inception. Through June of 2009, 942 youth have been referred through the Custody Division Protocol, with 96% successfully diverted from state custody. Of the youth diverted 32% were maintained with services in their home and community, and another 11% were only out of home for a brief period of time (less than one month). There are approximately 50 youth at any one time supported in an out of home placement through the Voluntary Placement Agreement. The Transfer of Custody (Senate Bill 1003) initiated at approximately the same time allows the Family Support Team of children in Children's Division custody to review for appropriateness of transferring the child's legal custody back to their parents due to

the absence of abuse/neglect or significant safety issues. Both the Diversion Protocol and Transfer Protocol are supported through interagency agreements related to funding of mental health services, with Children's Division providing support through the Voluntary Placement Agreement and funding following the child when transferred out of Children's Division custody.

Missouri Department of Mental Health and MO HealthNet Program Prescribing Practices Project. This project began in January 2003 through formal agreements between the DMH, MHD, and Comprehensive Neuroscience.

The goal of the project is to improve patient outcomes by improving psychiatric prescribing practices, improving continuity of care across multiple prescribers, and improving patient adherence to medication treatments for patients in the MO HealthNet program. Secondary goals include containing pharmacy costs and maintaining access to the open formulary of psychiatric medications.

The project's method and interventions are based on the following principles: (1) prescribing and pharmacy utilization management decisions should be based on data instead of anecdote; (2) interventions should make use of existing data sets and support the current prescribers; and (3) interventions should be respectful of physician/patient autonomy and minimize unintended consequences. The project assumes that prescribing consistent with nationally recognized best practice standards will lower overall health care costs and that prescribers will voluntarily adhere to national standards when they know what they are.

Evidence-based and expert consensus medication practice guidelines from the peer-reviewed literature are used to identify medication prescription patterns that are usually inconsistent with best practice. Pharmacy claims from MHD are transmitted to Comprehensive Neuroscience for monthly analysis to identify prescribing patterns falling outside nationally recognized best practice guidelines. The DMH Medical Director and MHD Pharmacy Director determined areas of prescribing practice to focus educational alerts to outlier prescribers for quality improvement. The number of prescribers, both psychiatrist and primary care, who receive monthly mailings varies from 1,500 to over 3,000 a month. Prescribers receive a cover letter identifying areas of prescribing concern, patient specific information and educational monographs describing the relevant best practice guideline(s). In addition, the project alerts all Missouri physicians of patients who failed to refill their antipsychotic medications in a timely fashion or were prescribed multiple drugs of the same chemical class concurrently from different physicians. Prescribers also receive a report of all psychiatric medications their patients have received in the previous 90 days including date, dosage, prescriber (including those other than themselves) and dispensing pharmacy. Prescribers are offered telephone consultation by psychiatrists with specific psychopharmacology expertise.

Prescription of psychiatric medications for the treatment of mental illness is the most common and most effective treatment modality currently available. There are very few innovative programs focused on improving the quality and outcomes of psychiatric prescribing and none that have been acknowledged with a Gold award from the Utilization Review Accreditation Commission (URAC). The partnership is led by a psychiatrist and has successfully improved the quality of psychiatric prescribing by both psychiatrists and primary care prescribers and has demonstrated improved clinical outcomes and cost savings. The partnership is widely recognized as a national innovation and has been rapidly replicated throughout the nation. It has continuously improved its method and continues to innovate new approaches.